STATE OF CALIFORNIA
DEPARTMENT OF MANAGED HEALTH CARE

TITLE 28, CALIFORNIA CODE OF REGULATIONS
DIVISION 1. THE DEPARTMENT OF MANAGED HEALTH CARE
CHAPTER 2. HEALTH CARE SERVICES PLANS
ARTICLE 7. STANDARDS

PROPOSED ADOPTION OF SECTION 1300.67.2.2

PROPOSED TEXT
Control No. 2005-0203

Adopt new section 1300.67.2.2 as follows:

1300.67.2.2 Timely Access To Health Care Services

(a) Application. This section shall apply to all health care service plans that provide or arrange for the provision of hospital or physician services, including specialized mental health plans that provide physician or hospital services, or that provide mental health services pursuant to a contract with a full service plan.

(1) The obligation of a plan to comply with this section shall not be waived when the plan delegates to its medical groups, independent practice associations, or other contracting entities any services or activities that the plan is required to perform.

(2) This section clarifies requirements for plans to monitor and ensure the adequacy of contracted provider networks and does not establish performance requirements for individual health care providers. Plan and provider delegation contracts shall comply with the requirements of Section 1375.7 of the Act and section 1300.70(b)(2)(G) and (H) of Title 28.

(3) This section does not create a new cause of action or a new defense to liability for any person.

(b) Definitions. For purposes of this section, the following definitions apply.

(1) "Advanced access" means the provision, by an individual provider, or by the medical group or IPA to which an enrollee is assigned, of: non-urgent appointments with a primary care physician on the same day the appointment is requested; non-urgent appointments with a specialist within 5 business days of the appointment request; and advance scheduling of appointments at a later date if the enrollee prefers not to accept the appointment offered on the same day (for primary care physicians) or within 5 days (for specialist physicians).

(2) "Appointment waiting time" means the time from the initial request for health care services by an enrollee or the enrollee's treating provider to the earliest date offered for the appointment for services inclusive of time for obtaining authorization from the plan or completing any other condition or requirement of the plan or its contracting providers.

(3) "Preventive care" means health care provided for prevention and early detection of disease, illness, injury or other health condition and, in the case of a full service plan includes but is not limited to all of the basic health care services required by section 1300.67(f) of Title 28.

(4) "Provider group" has the meaning set forth in Section 1373.65(g) of the Act.

(5) "Referral time" means the time from an appointment with a contracted health care provider during which the provider determines the need to refer an enrollee to another provider (recipient provider) for additional examination, evaluation, treatment or other care, to the time the referring provider delivers, to the plan or to the recipient provider, a written request for the additional health care services.

(6) "Routine care" means care that is not emergency, urgent or preventive care, such as, but not limited to, care delivered during problem-oriented office consultations with primary care and specialist physicians, and periodic follow up care, monitoring and treatment for chronic conditions.

(7) "Telephone waiting time" means the time on the telephone waiting to speak to, including time waiting for a return call from, a physician, registered nurse, or other qualified health professional acting within his or her scope of practice and who is trained to screen or triage an enrollee who may need care.

(8) "Urgent care" means health care for a condition which requires prompt attention, consistent with section 1367.01(h)(2).

(c) Quality Assurance Processes. All plans shall have written quality assurance processes designed to achieve timely access in compliance with the requirements of this section. The written policies and procedures shall include, at a minimum:

(1) Standards for the provision of covered services in a timely manner consistent with professionally recognized standards of practice, and established in accordance with the requirements set forth in subsection (d).

(2) Requirements for plan monitoring for compliance with the requirements of this section. A plan shall monitor its contracted provider network for patterns of non-compliance and for incidents of noncompliance resulting in substantial harm to an enrollee. The plan's monitoring shall be designed to ensure that the plan's network is sufficient to provide accessibility, availability and continuity of covered health care services as required by the Act and this section, and in accordance with the plan's timely access standards established pursuant to subsection (d). Plan monitoring shall include, at a minimum:

(A) An annual, statistically valid, enrollee satisfaction survey. The survey shall be conducted in accordance with valid and reliable survey methodology, and designed to ascertain enrollee satisfaction with respect to each of the indicators for timely access set forth in the plan's policies and procedures. Plans that survey enrollees with the Consumer Assessment of Health Plans Study (CAHPS) or the Experience of Care and Health Outcomes (ECHO) in connection with certification by the National Committee for Quality Assurance (NCQA), may meet the requirements of

this subsection by including appropriate supplemental questions, as approved by the Department, with the NCQA survey.

(B) An annual provider satisfaction survey of not less than 5% of the contracted primary care physicians and not less than 5% of the aggregate contracted specialty care providers in each county of a plan's service area. Plans and providers may cooperate to develop, subject to the Department's approval, uniform provider survey forms, and to share survey data to avoid redundant and duplicative surveys of provider groups, so long as these collaborative processes are designed to solicit and obtain responses from different providers in successive years.

(C) Review, on not less than a monthly basis, of the information regarding accessibility, availability and continuity of care available to the plan, including but not limited to, information developed from enrollee complaints and grievances, plan monitoring of provider performance, and screening and triage activities pursuant to subsection (d)(5).

(D) Contracts between a plan and a provider group shall require the provider group to cooperate with the plan as necessary to enable the plan to comply with the reporting requirements established by Section 1367.03(f)(1) of the Act and by subsection (e)(2).

(3) A plan shall implement prompt investigation and corrective action when compliance monitoring identifies timely access deficiencies. A plan shall take all necessary and appropriate action to identify the cause(s) underlying identified timely access deficiencies and to bring its network into compliance, including but not limited to, as applicable to the root cause, contracting with additional providers, increasing the application of advanced access within contracted provider groups, increasing access through expansion of telemedicine and other technological mechanisms, and delivering additional provider education and training regarding plan processes, procedures and systems that support the delivery of timely access by contracted providers.

(4) Standards, procedures and systems to ensure that, if a contracted provider or provider group is unable to deliver timely access in accordance with the standards of this section, the plan or its delegated provider group shall arrange for the provision of a timely appointment with an appropriately qualified and geographically accessible provider within the plan's network. This requirement does not prohibit a plan or its delegated provider group from accommodating an enrollee's preference to wait for a later appointment from a specific provider.

(d) Plan Standards for Access to Care.

(1) Plans shall provide or arrange for the provision of covered health care services in a timely manner appropriate for the nature of the enrollee's condition consistent with good professional practice.

(2) A plan's standards for timely access shall be established using the following indicators of timely access to care unless the plan obtains the Department's prior approval by written Order for alternative standards through the process set forth in subsection (e)(5):

(A) Appointment waiting times, which shall be tracked separately for each of the following categories of providers: (i) primary care physicians; (ii) specialty care physicians; (iii) mental health providers; and (iv) providers of ancillary services, for each of the following categories of care: routine care, preventive care, and urgent care appointments;

(B) Referral times in an episode of illness, injury or other health condition; and

(C) Telephone waiting times.

(3) A plan's standards for the indicators listed in subsection (d)(2):

(A) Shall be developed with involvement from actively practicing health care providers;

(B) Shall be consistent with sound clinical principles and processes;

(C) Shall be evaluated, and updated if necessary, at least annually; and

(D) May be uniform timely access standards based on industry best practices, developed cooperatively by plans and health care providers in accordance with the requirements of this section and subject to the Department's approval.

(4) A plan may demonstrate compliance with the requirements of this section through implementation of standards, processes and systems providing advanced access, as defined at subsection (b)(1), to appointments for health care services.

(5) A plan or delegated provider group that does not provide advanced access to appointments shall have systems and personnel sufficient to ensure that:

(A) A qualified health care professional, acting within the scope of his or her practice and trained to screen or triage, is readily available by telephone during normal business hours to provide prompt screening and triage, and to advise enrollees and providers regarding the time in which an enrollee should see a physician, or to receive ancillary care services, and to facilitate arranging for appointments in a timely manner as appropriate for the enrollee's condition and health care needs.

(B) The screening and triage activities conducted pursuant to subsection (d)(5)(A) and the resulting appointments are documented, monitored, and evaluated through the plan's quality assurance program to ensure full compliance with the requirements of this section and with the plan's internal policies and procedures.

(C) The telephone wait time for an enrollee or to speak with a qualified health care professional pursuant to subsection (d)(5)(A) regarding the enrollee's health care condition or need for an appointment shall not exceed five minutes. After hours and weekends, plan and provider medical advice and triage lines shall provide clear recorded instructions regarding how to obtain urgent or emergency care.

(D) When it is necessary for a provider or an enrollee to cancel an appointment, the enrollee is offered an alternative appointment in a timely fashion appropriate for the

nature of the enrollee's condition and is not subjected to multiple provider cancellations that may disrupt continuity of care or otherwise delay timely access contrary to the requirements of Section 1367.03 of the Act and this section.

(e) Filing, Implementation and Reporting Requirements.

(1) Not later than December 31, 2008, plans shall have implemented the policies, procedures and systems necessary for compliance with the requirements of Section 1367.03 and this section. Not later than October 1, 2008, each plan shall file an amendment pursuant to Section 1352 of the Act disclosing how it will achieve compliance with the requirements of this section, which shall include:

(A) The plan's policies and procedures for ensuring timely access in accordance with the requirements of this section, including clinically appropriate access standards for all indicators set forth in the plans' policies and procedures, together with information in support of the standards; and for any variations proposed for geographic areas in which there are shortages of particular types of providers.

(B) The plan's forms of enrollee and provider satisfaction surveys and, if applicable, any supplemental questions to be included with enrollee surveys conducted pursuant to NCQA accreditation processes.

(C) The disclosures in evidences of coverage and enrollee educational material informing enrollees how to obtain timely appointments and what to do if the enrollee encounters problems in scheduling appointments.

(D) Amendments to provider and other contracts as necessary for compliance with Section 1367.03(f)(1) of the Act and with subsection (a).

(2) By July 31, 2010, and by July 31 of each year thereafter, every full service plan shall file with the Department a report, pursuant to Section 1367.03(f)(2) of the Act, regarding compliance during the immediately preceding year. The first reporting period shall be the calendar year ending December 31, 2009. The reports shall document the following information:

(A) The plan's timely access standards for all indicators set forth in the plan's policies and procedures.

(B) The rate of compliance, during the reporting period, with each of the plan's timely access standards, separately reported for each of the plan's contracted provider groups located in each county of the plan's service area.

(C) Whether the plan identified, during the reporting period, any incidents of noncompliance resulting in substantial harm to an enrollee and, if so, a description of the incident, and a description of the plan's investigation, determination and corrective action taken in response to each incident.

(D) Whether the plan identified, during the reporting period, any patterns of non-compliance identified by the plan during the reporting period and, if so, a

description of each pattern of non-compliance, including the provider group affected and its location (county), and a description of the plan's investigation, determination and corrective action taken in response to each identified pattern of non-compliance.

(E) A list of all provider groups and individual providers utilizing advanced access appointment scheduling.

(F) A description of the implementation and use by the plan and its contracting providers of triage, telemedicine, and health information technology to provide timely access to care.

(G) The results of the most recent annual enrollee and provider satisfaction surveys and a comparison with the results of the prior year's survey, including a discussion of the relative change in satisfaction.

(3) In approving or disapproving a plan's proposed standards for timely access, the Department may consider all relevant factors, including but not limited to:

(A) The availability and distribution of primary care physicians, specialty physicians and other types of providers within a service area;

(B) The adequacy of a plan's mechanisms to make alternative arrangements for enrollees when contracting providers are unable to meet the standards;

(C) The adequacy of a plan's mechanisms for evaluating and responding to sudden changes in utilization patterns;

(D) The factors set forth at Section 1367.03(d) and (e); and

(E) Other factors that the Director deems appropriate in the public interest and consistent with the intent and purpose of the Act as applied to specific facts or circumstances.

(4) In determining a plan's compliance or non-compliance with the requirements of this section, the Department will focus more upon patterns of non-compliance than isolated episodes of non-compliance and may consider all relevant factors, including but not limited to:

(A) The efforts by a plan to evade the standards, such as referring enrollees to providers who are not appropriate for an enrollee's condition;

(B) The nature and extent of a plan's efforts to avoid or correct non-compliance;

(C) The nature and extent to which a single instance of non-compliance results in, or contributes to, serious injury or damages to an enrollee;

(D) The extent to which non-compliance is the result of an urgency or emergency affecting a provider or provider group;

(E) The occurrence of sudden changes in utilization patterns; that are not reasonably foreseeable by a plan or within a plan's control, and which result in provider shortages which cannot be addressed though referrals to other providers; and

(F) Other factors established in relevant provisions of law, and other factors that the Director deems appropriate in the public interest and consistent with the intent and purpose of the Act as applied to specific facts or circumstances.

(5) A plan may propose, by filing a notice of material modification, for the Department's prior approval by written Order, timely access standards other than time elapsed standards for the indicators listed in subsection (d)(2). The notice of material modification shall include a comprehensive explanation of: the plans' clinical and operational bases for the proposed alternative standard; the expected impact on clinical outcomes and on contracted health care providers; and reliable and verifiable data supporting the plan's proposed alternative standards. The burden shall be on the plan to demonstrate and substantiate why a proposed alternative standard is more appropriate than time elapsed standards.

Authority: Sections 1344, 1346 and 1367.03, Health and Safety Code.
Reference: Sections 1342, 1367, 1367.01, 1367.03, 1370, 1375.7, and 1380, Health and Safety Code.